MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93 d

CERTIFICATE OF DEATH

03707

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
132 Penn. Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 132 Penn. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Reuben Henry Barnes

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Annie Horton
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Dec. 28 - 1859

8. AGE:

Years	Months	Days	If less than one day
88	3	10	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name James Barnes
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Kitty Shipley
15. Birthplace Carroll Co. Md.
16. Informant Mrs. Nellie Fogle
Address 132 Penn. Ave. Westminster, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10. 1948 (month) (day) (year)
Cemetery or crematory Ebenezer Cem.
Location Winfield, Md.
18. Funeral director D.B. Bankard & Son
Address Westminster Md.
19. 4/9 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948 at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 19.. to April 8 1948
and that I last saw h.. im alive on April 8 1948

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr)	10 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D.
M. D. or other
Address Westminster Md. Date signed 4-8-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Time correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

03708

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195 d

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural - Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural - Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Irvin Bauerlein

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 12, 1948

8. AGE:

Years	Months	Days	If less than one day
0	2	23	hrs. min.

9. Birthplace Taneytown, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Irvin James Bauerlein

13. Birthplace Md.

MOTHER 14. Maiden name Thelma L Hyser

15. Birthplace Penna.

16. Informant Mrs Irvin Bauerlein

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 6, 1948 (month) (day) (year)

Cemetery or crematory Piney Creek Cemetery

Location Taneytown, Md.

18. Funeral director C O Fuss & Son

Address Taneytown, Md.

19. April 5 1948 Ethel M Mehring Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION Between 4.30 and 8.50 A M

20. DATE OF DEATH April 4 1948 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death Suffocation — DURATION

Due to Upper Respiratory disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T Shord Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 4/4/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03709

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 8 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 year, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3318 Egerton Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mildred Ethel Beall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 1, 1893

8. AGE: Years	Months	Days	If less than one day
54	4	17	hrs. min.

9. Birthplace: Ann Arundel County (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Judge Lemon Beall
13. Birthplace: Prince Georges County

MOTHER
14. Maiden name: Ann Regina Anderson
15. Birthplace: Ann Arundel County

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 21 1948 (month) (day) (year)
Cemetery or crematory: Dandsonville
Location: A. A. Co. Md
18. Funeral director: John D Mitchell & Sons
Address: 1900 Eutaw Place
19. Apr. 18 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18, 19 48 at 1.55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9, 19 47, to April 18, 19 48 and that I last saw her alive on April 18, 19 48

	DURATION
Immediate cause of death	
Due to: Multiple sclerosis with optic xxxx atrophy	about 28 years
Due to:	
Other conditions: Psychosis associated with organicchanges of nervous system (multiple sclerosis)	8 years

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Wehrmeyer, M.D.
M. D. or other
Address: Springfield State Hospital Date signed 4-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03710

13L

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month 29 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. Market Street
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Dora Bratten

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 23, 1919

8. AGE: Years	Months	Days	If less than one day
28	6	26	..... hrs. ..... min.

9. Birthplace Snow Hill, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name James Edward Bratten
13. Birthplace Snow Hill, Maryland

MOTHER
14. Maiden name Laver Collick
15. Birthplace Snow Hill, Maryland

16. Informant Brother- Mr. Rossie Bratten

Address Snow Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-21-48 (month) (day) (year)

Cemetery or crematory Mt Wesley

Location Snow Hill Md

18. Funeral director Clay E Dennis

Address Snow Hill Md

19. April 18 1948 (Date rec'd by registrar) Albert R. Smith Registrar
Local Deputy

MEDICAL CERTIFICATION P.

20. DATE OF DEATH April 18 1948 at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20 1948 to April 18 1948 and that I last saw her alive on April 18 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman M.D.
M. D. or other

Address Henryton, Maryland Date signed 4/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

934

03711

Reg. Diat. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Rural - Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural - Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah Jane Brower

3. (b) Social Security Number none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Vernon S Brower

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 22, 1882

8. AGE: Years: 65 | Months: 10 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: Own home

FATHER 12. Name: Rufus H. Reaver

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Sarah C. Fair

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs Paul Brower

Address: Taneytown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9, 1948 (month) (day) (year)

Cemetery or crematory: Reformed Cemetery

Location: Taneytown, Maryland

18. Funeral director: C O Fuss & Son

Address: Taneytown, Maryland

19. April 9, 1948 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6th 1948 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Feb. 1st 1946 to Apr. 6th 1948

and that I last saw h[illegible] alive on Apr. 6th 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 days
Due to: Cardio-Vascular disease with hypertension	5 years
Due to:	
Other conditions: nun	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. T. Billingslea M.D. M. D. or other

Address Westminster, Md. Date signed 4-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03712

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 16 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2219 Pennsylvania Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nathaniel Brown

3.(b) Social Security Number: 219-07-1772

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Addie Brown

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): August 16, 1920

8. AGE: Years	Months	Days	If less than one day
27	7	17	..... hrs. ..... min.

9. Birthplace: Charlotte, N. Carolina
(Town, county, and state)

10. Usual occupation: Photographer

11. Industry or business:

FATHER
12. Name: Edward Brown
13. Birthplace: Charlotte, N. Carolina

MOTHER
14. Maiden name: Ella Fields
15. Birthplace: Bennettsville, S. Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-14-48 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Baltimore City

18. Funeral director: Geo. G. Kelson

Address: 130 B Preston St.

19. April 10 1948 (Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: April 10, 1948 at 5:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17 1948 to April 10 1948 and that I last saw him alive on April 10 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben T. Bowman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 4/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03713

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 month 3 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 649 W. Lee Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Elizabeth Bryant

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30, 1933

8. AGE: Years	Months	Days	If less than one day
14	8	21	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: Herbert Bryant
13. Birthplace: Salters, S.Carolina

MOTHER
14. Maiden name: Sarah Buster
15. Birthplace: Claremont, Virginia

16. Informant: Deceased
Address:

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 4/24/48 (month) (day) (year)

Cemetery or crematory: Petersburg

Location: Virginia

18. Funeral director: Isaiah L. Brandon

Address: 108 W Montgomery St

19. April 21 19 48 (Date rec'd by registrar) Albert R. Brandon Registrar
Local Deputy

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: April 21 19 48 at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 19 47 to April 21 19 48

and that I last saw her alive on April 21 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M. D.
M. D. or other

Address: Henryton, Maryland Date signed 4-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03714

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 2 month 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1628 Mc Culloh Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Homer Buffington

3. (b) Social Security Number: 228-09-0121

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Rachel Buffington
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): February 23, 1901

8. AGE: Years	Months	Days	If less than one day
47	1	14	...hrs. ...min.

9. Birthplace: Georgia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Dilard Buffington
13. Birthplace: Georgia
MOTHER 14. Maiden name: Mattie Gilmor
15. Birthplace: Georgia
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 12th. 1948 (month) (day) (year)
Cemetery or crematory: St. Peters
Location: Baltimore, Maryland
18. Funeral director: Joseph L. Russ
Address: 1200 McCulloh Street
19. April 8 19 48 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: April 8 19 48 at 5:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13 19 47 to April 8 19 48 and that I last saw him alive on April 8 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Lowman, M. D. (M. D. or other)
Address: Henryton, Maryland Date signed: 4/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

03715

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 month

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 929 N. Mount Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anita Carter Corbin

3.(b) Social Security Number: 216-24-4106

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Separated

6.(b) Name of husband or wife: Ellsworth Corbin

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): March 25, 1926

8. AGE: Years: 22 | Months: 0 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Clay Brooks Carter
13. Birthplace: North Thumland Virginia

MOTHER
14. Maiden name: Minnie Nutt
15. Birthplace: North Thumland, Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8-48 (month) (day) (year)

Cemetery or crematory: Baltimore City

Location: Mt. Auburn

18. Funeral director: Geo. S. Kelson

Address: 1303 Pressman. St.

19. April 5 1948 (Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: April 5 1948 at 1:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1948 to April 5 1948 and that I last saw her alive on April 5 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Shuman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 4/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

03716

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Patapsco (Rural) (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Patapsco (Rural) (if outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Florence A. Davidson
3. (b) Social Security Number: —

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: M
6.(b) Name of husband or wife: Edward F Davidson
6.(c) If alive, give age: 79 years
7. Birth date of deceased (mo., day, yr.): Nov 24-1869
8. AGE: Years 78 Months 4 Days 26 If less than one day ... hrs. ... min.
9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Hef
11. Industry or business
FATHER 12. Name: Noah Brasher
13. Birthplace: Md
MOTHER 14. Maiden name: Belinda Miller
15. Birthplace: Md
16. Informant: Edw F Davidson
Address: Upperco Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 22/48 (month) (day) (year)
Cemetery or crematory: Wesley
Location: Carroll Co Md
18. Funeral director: Edw C Tipton
Address: Hampstead Md
19. 4/21 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1948, at 5:00 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to April 20 1948 and that I last saw her alive on April 19 1948

	DURATION
Immediate cause of death: Coronary Arterio-Sclerosis c̄	8 years
Due to: Congestive Heart Failure	6 mo
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Maurice C. Porterfield M.D. or other
Address: Hampstead Md Date signed: 4-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03717

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll Co

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 6 mos. 10 da

Hospital, Institution, or street address where death occurred: Spring field State Hospital

How long in hospital or institution? 1 yr. 6 mos. 10 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Eli DeShon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Margaret Boor

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): May 28 - 1873

8. AGE: Years: 74 Months: 10 Days: 28 If less than one day: ... hrs. ... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Shirt Cutter

11. Industry or business: Sykesville Dept. retired

FATHER 12. Name: William DeShon

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Adelaide Gibson

MOTHER 15. Birthplace: Md.

16. Informant: Mrs Margaret Boor

Address: 4403 Forest View Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 30 (month) (day) (year)

Cemetery or crematory: Lakewood

Location: Taylor Ave, Balto

18. Funeral director: Estate Agnes M Lutz

Address: 200 N. Broadway

19. 4/30 19 48 Dan. Hedrick Jr. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 19 48 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 19 46 to April 27 19 48 and that I last saw h... alive on April 27 19 48

Immediate cause of death	DURATION
Coronary Thrombosis	2
Due to Cerebral Arterio Sclerosis	10 yrs
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: H. L. Gaston M.D. M. D. or other

Address: Sykesville Date signed: 4/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 K

03718

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

T

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month 5 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Licksville, P.O Tuscarora, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME: Annie Elizabeth Diggs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William Diggs

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): June 2, 1919

8. AGE: Years	Months	Days	If less than one day
28	10	14	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Clarence Dyson

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Nora Dimes

15. Birthplace: Maryland

16. Informant: Deceased

Address

17. (Burial, cremation, or removal Which?) Removal Date thereof: April 16 1948 (month) (day) (year)

Cemetery or crematory: Quince Orchard

Location: Rockville Md.

18. Funeral director: R. L. Snouffer

Address: Rockville, Md.

19. April 16 1948 (Date rec'd by registrar) Albert R. Smantham Local Deputy Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: April 16 19 48 at 3:25 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 11 19 48 to April 16 19 48 and that I last saw her alive on April 16 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Helen C. Hoffman M. D. M. D. or other

Address: Henryton, Maryland Date signed: 4/16/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

928 pm 03719 74

Reg. Dist. No.

1: PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 10 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 6 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: - - -

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4502 Carleview Road, Balto. 7
(If rural, give LOCATION)

2.(a) If veteran, name war: - - -

3. (a) FULL NAME

Ender, Edmund Ambrose Ender

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Elizabeth Samuel, Ender

- - - 6.(c) If alive, give age - - - years

7. Birth date of deceased (mo., day, yr.): April 10, 1852

8. AGE: Years	Months	Days	If less than one day
96	0	11	....hrs. ....min.

9. Birthplace: Berlin, Germany
(Town, county, and state)

10. Usual occupation: retired clothing salesman

11. Industry or business: - -

FATHER
12. Name: Charles J. Ender
13. Birthplace: Germany

MOTHER
14. Maiden name: - - -
15. Birthplace: Germany

16. Informant: Records of Springfield St. Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 26, 1948 (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: New Haven, Conn.

18. Funeral director: Wilbur Lamoreaux

Address: 4510 Liberty Heights Ave.

19. 4/23 19 48 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 19 48 at 4:07 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1948, to April 21 1948 and that I last saw him alive on April 21 1948

Immediate cause of death	DURATION
Arteriosclerosis	3 years
Due to: - - -	
Due to: - - -	
Other conditions: Mitral insufficiency; Left sided paresis; Left sided ing. hernia.	? / 3 years / ?

(Include pregnancy within 3 months of death)

Major findings of operation: - - - Date of op. - - -

Autopsy results: - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - - - Date of: - - -

Where did injury occur? - - - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): - - -

Means of injury: - - - Injured at work? - - -

23. SIGNATURE: Martin Gross, M.D.
Martin Gross, M. D. M. D. or other

Address: Sykesville, Maryland Date signed: 4/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

526 / 03720

Reg. Dist. No. 8 2

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George P. B. Englar

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Mary L. Englar

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 17 - 1867

8. AGE:

Years	Months	Days	If less than one day
80	8	20	hrs. min.

9. Birthplace: Carroll County, Md

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER

12. Name: Elbanan W. Englar

13. Birthplace: Maryland

MOTHER

14. Maiden name: Margaret Bixler

15. Birthplace: Maryland

16. Informant: Mrs. Mary L. Englar

Address: New Windsor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9 - 1948 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: W. H. Hafer & Sons

Address: Union Bridge & New Windsor, Md

19. 4/7/48 (Date rec'd by registrar) 1948 Chas. Bixler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1948, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945, to Apr. 6 1948

and that I last saw him alive on April 6 1948

Immediate cause of death: Carcinoma of Bladder — DURATION: 2 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh M. D.

Address: Westminster Md M. D., or other

Date signed: Apr 7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name if name given is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

03721

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 27 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?

(If rural, give LOCATION)

2.(a) If veteran, name war: ----

3.(a) FULL NAME: FISHER, James

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): July 11, 1856

8. AGE: Years	Months	Days	If less than one day
91	9	8	....hrs. ....min.

9. Birthplace: Frederick, Frederick, Maryland (Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business: ----

FATHER — 12. Name: Hugh Fisher

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Maria ?

MOTHER — 15. Birthplace: Md.

16. Informant: Records of Springfield State Hosp.

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-20-48 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Frederick, Md.

18. Funeral director: Henry C. Carty Co.

Address: Frederick, Md.

19. Apr. 20 1948 C. Harry Zile (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1948 at 9.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947, to April 19, 1948

and that I last saw him alive on April 19, 1948

	DURATION
Immediate cause of death: Chronic myocarditis	10-20 yrs
Due to: Arteriosclerosis	more than 21 yrs
Due to: Jaundice (Liver carcinoma?)	3 months
Other conditions: Fracture of femur	2 weeks
Psychosis with cerebr. arterio-	
(Include pregnancy within 3 months of death) sclerosis	21yrs

Major findings of operations: ----

Date of op.: ----

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Acc. Date of 4/5/48

Where did injury occur? Springfield State Hosp. (City or town) Carroll Co. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Hosp.

Means of injury: Fall Injured at work? ----

23. SIGNATURE: Martin Gross, M.D.

Martin Gross, M.D.

Address: Sykesville, Md

M. D. or other

Date signed: 4-19-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03722

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:

County: Carroll

City or town: Keymar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Keymar

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George W. Fox

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Sarah Ellen Fox

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1862

8. AGE: Years	Months	Days	If less than one day
86	3	3	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER 12. Name: Samuel Fox

13. Birthplace: Md

MOTHER 14. Maiden name: Mary Young

15. Birthplace: Md

16. Informant: Mrs. Geo. E. Deberry,

Address: Keymar, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12, 1948. (month) (day) (year)

Cemetery or crematory: Keysville

Location: Keysville, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19. April 10 1948 (Date rec'd by registrar) James M. K. Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1948, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1947 to April 9 1948

and that I last saw h[illegible] alive on April 8 1948

Immediate cause of death	DURATION
Cancer - Intestines	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D. H. Legg M. D. or other

Address: Union Bridge Date signed 4-10-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03723

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 28 Church

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Etta Frederickhauser

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Adam C. Frederickhauser

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 22. 1865

8. AGE:

Years	Months	Days	If less than one day
83	1	9	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name James Downey

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Mary E. Lockard

15. Birthplace Carroll Co. Md.

16. Informant Mrs. John Utermahlen

Address 28 Church St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3. 1948 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard Son

Address Westminster Md.

19. 4/2 1948 (Date rec'd by registrar) C. C. Armacost Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to April 1 1948

and that I last saw her alive on April March 30 1948

Immediate cause of death Hemiplegia — DURATION 2 weeks

Due to Cerebral Hemorrhage — 2 weeks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reese Wilbers M. D. or other

Address Westminster Date signed 4/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03724 83

Reg. Diat. No. .....

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Morgan
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Morgan
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural --Woodbine
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LEVI D. FRIZZELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Virginia Frizzell
deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1847

8. AGE: Years	Months	Days	If less than one day
100	5	10	..... hrs. ..... min.

9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Retired

FATHER
12. Name: Jesse W. Frizzell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rosanna Demmitt
15. Birthplace: Maryland

16. Informant: Mrs. Alberta Gosnell
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 4-12-48 (month) (day) (year)
Cemetery ~~or crematory~~: Sam's Creek Brethren
Location: Dennings Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. April 12 1948 (Date rec'd by Registrar) Edna M. Hewett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9th 1948 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15th 1947 to April 9th 1948 and that I last saw h.im alive on April 9th 1948

Immediate cause of death	DURATION
Acute Pneumonitis	4 da.
" Bronchopneumonia	14 d
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE: L. C. Stitely M.D. M. D. or other
Address: New Windsor Md. Date signed 4/9/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 939

CERTIFICATE OF DEATH

03725

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Rural, Melrose
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural (Melrose)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME (m) Amdilla E. Fuhrman

3.(b) Social Security Number /

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband (Deceased) Levinus Fuhrman
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) March 20, 1868

8. AGE: Years 80 | Months 0 | Days 14 | If less than one day ____ hrs. ____ min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business

FATHER
12. Name Jacob Wilson
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Catherine Fuhrman
15. Birthplace Unknown

16. Informant Mrs. George Humbert
Address Westminster Md R.D.#3

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-7-48 (month) (day) (year)
Cemetery or crematory Cemetery
Location Sherman Church (St. Davids)

18. Funeral director Jacob Wink's Sons
Address Manchester Md

19. Apr. 5 1948 Mrs. W. R. S. Deems
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1948 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 1947 to April 4 1948 and that I last saw her alive on March 16, 1948

Immediate cause of death	DURATION
a. Myocardial degeneration	3 mos+
Due to: arteriosclerosis	2+ yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Reese Wilbur M.D.
M. D. or other
Address Westminster Date signed 4/4/48

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03726

59a

Reg. Dist. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 9 yrs.

Hospital, Institution, or street address where death occurred:

114 Liberty Ext

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 Liberty Ext

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Laura Isadora Gentz

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife George M. Gentz

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb. 27 - 1887

8. AGE:

Years	Months	Days	If less than one day
59	1	19	....hrs. ....min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Samuel A. Brumbaltz

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Emma V. Pickle

15. Birthplace Carroll Co. Md.

16. Informant George M. Gentz

Address 114 Liberty St. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19 1948 (month) (day) (year)

Cemetery or crematory Wesley Lutheran Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 4/19 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947, to Apr 16 1948

and that I last saw h.er alive on Apr 16 1948

	DURATION
Immediate cause of death Inanition	6 weeks
Due to Rheumatoid Arthritis	12 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James V Mason M. D. or other

Address Westminster Md Date signed 4/17/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 938

03727

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Mos; 15 Days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 7 Mos; 15 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County ———

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown
(If rural, give LOCATION)

2.(a) If veteran, name war ———

3. (a) FULL NAME GLEASON, Frank

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife ———

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1878 Or 1879

8. AGE: Years	Months	Days	If less than one day
68 or 69	5	9	..... hrs. ..... min.

9. Birthplace Deansville, N.Y.
(Town, county, and state)

10. Usual occupation Foreman - Casket work

11. Industry or business ———

FATHER
12. Name Michael Gleason
13. Birthplace Germany

MOTHER
14. Maiden name Julia Doyle
15. Birthplace New York

16. Informant Records of Springfield State Hosp.
Address Sykesville, Maryland

17. Burial Date thereof Apr. 20 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ———

Location Oneida New York

18. Funeral director Harry Heer

Address Sykesville, Md.

19. Apr. 17 1948 Harry Heer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947 to April 16 1948 and that I last saw him alive on April 16 1948

	DURATION
Immediate cause of death: Heart failure	2 days
Due to: Chronic myocardial disease	1 year
Due to:	
Other conditions: Ulcerative stomatitis	4 days
Agitated depression (Include pregnancy within 3 months of death)	15 years

Major findings of operations ———

Date of op. ———

Autopsy results ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of Injury ——— Injured at work? ———

Martin Gross, M.D.

23. SIGNATURE Martin Gross, M.D.
M. D. or other

Address Sykesville, Md Date signed 4-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03728

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH:
County: Carroll
City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HARVEY G. HAINES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Elizabeth A. Haines
deceased
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 25, 1868

8. AGE:

Years	Months	Days	If less than one day
79	5	17	____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Painter & Paperhanger
11. Industry or business: Retired

FATHER
12. Name: Henry W. Haines
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary C. Bowers
15. Birthplace: Maryland

16. Informant: Mrs. Leon Moore
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 4-14-48 (month) (day) (year)
Cemetery ~~or crematory~~: Pine Grove
Location: Mt. Airy, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19 April 14 19 48 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 1948 at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1948, to April 12 1948 and that I last saw him alive on April 11, 1948

Immediate cause of death	DURATION
Uremia	3 da
Due to Chr. Interstitial Nephritis	? yrs
Due to Gangrene Rt foot & leg	8 days
Due to Cardio-Renal-Vascular disease	5 yrs.
Other conditions Hemiplegia (rt.)	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt Airy, Md. Date signed 4/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03729

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Carroll
City or town: Finksburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Finksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mabel A. Harman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: John C. Harman
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): October 16, 1888

8. AGE: Years	Months	Days	If less than one day
59	6	2	..... hrs. ..... min.

9. Birthplace: Carroll County (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Chas. W. Myers
13. Birthplace: Md.

MOTHER
14. Maiden name: Clara E. Otto
15. Birthplace: Md.

16. Informant: John C. Harman
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2 1948 (month) (day) (year)
Cemetery or crematory: Bair
Location: Taneytown Road
18. Funeral director: C. O. Fuss & Son
Address: Taneytown, Md.
19. April 2 1948 (Date rec'd by registrar) Margaret R. Engler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1st 1948, at 10:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3rd 1948, to April 1st 1948
and that I last saw h... alive on April 1st 1948

	DURATION
Immediate cause of death: Acute Hypostatic Pneumonia	36 hrs
Due to: Acute Cerebral Hemorrhage	13 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Luther Bair M. D.
Address: Westminster, Md. Date signed: 4/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03730

932

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs. 1 month 15 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 10 yrs. 1 month 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County - - - Balt

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2907 Ohio Avenue (If rural, give LOCATION)

2.(a) If veteran, name war - --

3.(a) FULL NAME John Hettche, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Anna Hettche, dec.

- - - 6.(c) If alive, give age - - - years

7. Birth date of deceased (mo., day, yr.) December 2, 1878

8. AGE: Years	Months	Days	If less than one day
69	4	26	....hrs. ....min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation laborer

11. Industry or business - - -

FATHER 12. Name John Hettche

13. Birthplace Germany

MOTHER 14. Maiden name Louise Smith

15. Birthplace Germany

16. Informant Records of Springfield St. Hospital

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1948 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Baltimore Md.

18. Funeral director William Cook Inc.

Address Baltimore Md

19. Apr 28 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1948, at 2:16 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1948, to April 28 1948 and that I last saw him alive on April 28 1948

Immediate cause of death	DURATION
Chronic myocarditis	unkn.
Due to - - -	
Due to - - -	
Other conditions Prostatic hypertrophy	at least several wks
Alcoholic psychosis	12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation - - -

Date of op. - - -

Autopsy results - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin Gross, M.D. M. D. or other

Address Sykesville, Maryland Date signed 4/28/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

03731

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo.

Heepital, Institutien, er street address where death occurred:
Springfield State Hospital

How long in heepital er institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City er town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 N. Exeter Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JOHN L. HOLTHAUS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Separated

6.(b) Name of husband or wife: Addie Belle Cummings

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 9/21/85

8. AGE: Years	Months	Days	If less than one day
62	6	0	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Accountant

11. Industry or business: Unknown

FATHER
12. Name: Frederick Holthaus
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bridget McCall
15. Birthplace: Maryland

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 23 1948 (month) (day) (year)

Cemetery or crematory: Springfield

Location: Sykesville Md.

18. Funeral director: A Stanley Keen

Address: Sykesville Md.

19. Apr 22 1948 (Date rec'd by registrar) A Stanley Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21, 1948 at 9:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1948 to April 21, 1948 and that I last saw him alive on April 21, 1948

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Decubitus ulcer	3 wks.
Due to: Diabetes mellitus	? 1 mo.
Due to: Generalized arteriosclerosis	?
Other conditions	
Psychosis with syphilitic meningo-encephalitis	?

(Include pregnancy within 3 months of death)

Major findings of operations: Mid-thigh amputation, right leg, for diabetic gangrene Date of op. 3/23/48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 4/26/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

03732

2411 N. Charles St., Baltimore

136

CERTIFICATE OF DEATH

BC

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore - 24-
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1503 Swallow Circle
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES EDWARD HUTCHINS

3.(b) Social Security Number: 218-09-1621

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26, 1907

8. AGE:

Years	Months	Days	If less than one day
40	9	15	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: James Hutchins
13. Birthplace: Annapolis, Maryland

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 15 48 (month) (day) (year)

Cemetery or crematory: Mount Auburn

Location: Balto. Md.

18. Funeral director: Mrs. Katie B. Williams

Address: 3222 D Chowden St

19. April 11, 1948 (Date rec'd by registrar) Albert L. Swanson Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1948, at 4:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29, 1948, to April 11, 1948, and that I last saw him alive on April 11, 1948.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 1938
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 4-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

03733

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 6
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Elizabeth Irwin Jefferis

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Samuel Jefferis

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 4, 1869

8. AGE:

Years	Months	Days	If less than one day
79	3	16	..... hrs. ..... min.

9. Birthplace: Westminster, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: P. H. Irwin
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Helen Boyle
15. Birthplace: Maryland

16. Informant: Miss Mary Cunningham
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4/22/48 (month) (day) (year)

Cemetery or crematory: St. John's Catholic Cem.

Location: Westminster, Md.

16. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 4/20 (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1948 at 10½ a. m.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from July 1 1946 to Apr 20 1948 and that I last saw her alive on April 15 1948

Immediate cause of death: Cerebral hemorrhage — DURATION: 2 days

Due to: Arteriosclerosis — DURATION: 3 to 5 yrs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J Reese Jr MD

Address: Westminster M. D. or other

Date signed: 4/20/48

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

03734

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 15 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 months 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore - 14
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3306 Hamilton Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

ADELAINE (DELINA) LANCE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	~~M~~ W

6.(b) Name of husband or wife: late Joseph Lance

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 4/5/1881

8. AGE: Years	Months	Days	If less than one day
67	0	17	..... hrs. ..... min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Felone Civitarese
13. Birthplace: Italy

MOTHER
14. Maiden name: Mary ?
15. Birthplace: Italy

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. BURIAL (Burial, cremation, or removal, Which?) Date thereof APRIL 26 '48 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Rd

18. Funeral director: Harry A Wetzler

Address: 4101 Edmondson Ave

19. April 23 1948 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1948 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 7, 1948 to April 22, 1948 and that I last saw her alive on April 22, 1948

Immediate cause of death	DURATION
Psychosis with cerebral	
Due to: arteriosclerosis	4 yrs.
Due to:	
Other conditions: chronic myocarditis with myocardial degeneration	known Feb. 7, 1948

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 4/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

Adelaine

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

939 03735

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, Institution, or street address where death occurred:

Balto. Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Balto. Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eleanor Elizabeth Logue

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Francis A Logue

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 29 - 1872

8. AGE:

Years	Months	Days	If less than one day
75	6	27	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Henry B. Frank

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Mary A. Arndorff

15. Birthplace Littlestown, Pa.

16. Informant Miss Agnes A Logue

Address 5212 Norwood Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29 1948 (month) (day) (year)

Cemetery or crematory St. John's Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 4/27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 1948 at 9 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-24 1948 to 4-26 1948 and that I last saw h alive on 4-24 1948

	DURATION
Immediate cause of death Cerebral Hemorrhage	2 da.
Due to Cardio Vascular Disease	about 4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE N. J. Billingslea, M.D. M. D. or other

Address Westminster, Md. Date signed 4-27-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03736

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 2 month 26 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 617 Sarah Ann Street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward Diggs Mantiply

3.(b) Social Security Number 218-07-4608

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 28, 1912

8. AGE: Years	Months	Days	If less than one day hrs. min.
36	0	4	

9. Birthplace Lynchburg, Virginia (Town, county, and state)

10. Usual occupation Trackman

11. Industry or business

FATHER 12. Name Edward Mantiply

13. Birthplace Virginia

MOTHER 14. Maiden name Marie Johnson

15. Birthplace Virginia

16. Informant Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/5/1948 (month) (day) (year)

Cemetery or crematory Mt Calvary cem

Location [illegible] co

18. Funeral director [illegible]

Address [illegible]

19. April 1 1948 (Date rec'd by registrar) [signature] Registrar Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948, at 1:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 1947 to April 1 1948

and that I last saw him alive on April 1 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature], M.D. M.D. or other

Address Henryton, Maryland Date signed 4/1/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03737

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour 40 minutes

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1408 School Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Lebency Moon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 24, 1895

8. AGE: Years	Months	Days	If less than one day
53	1	20	hrs. min.

9. Birthplace: Cornville, Georgia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER — 12. Name: Robert Price

13. Birthplace: Cornville, Georgia

MOTHER — 14. Maiden name: Lula Bruce

15. Birthplace: Cornville, Georgia

16. Informant: Sister-Mrs. Mattie Lee Huntley

Address: 738 W. Saratoga St, Baltimore, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) 4 (day) 17 (year) 48

Cemetery or crematory: Mt Auburn

Location: Baltimore City

18. Funeral director: Geo. E. Kelson

Address: 1303 Preston St.

19. April 13 19 48 (Date rec'd by registrar) Albert R. Swankhorn Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 19 48 at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 19 48 to April 13 19 48 and that I last saw her alive on April 13 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 4/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03738

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 81

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4709 Norwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Grace R. Moran

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widowed

6.(b) Name of husband or wife William P. Moran

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 22 - 1875

8. AGE:

Years	Months	Days	If less than one day
72	4	4	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Jacob Fritz

13. Birthplace Maryland

MOTHER

14. Maiden name Lydia A. Brown

15. Birthplace Pennsylvania

16. Informant Robt. R. Moran

Address 4709 Norwood Ave - Baltimore Md

17. Burial. Date thereof 4 29 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Belair Rd - (Belair Rd)

18. Funeral director Selby & Zeibe Inc

Address 403 S. Wolfe St. Balto 31.

April 26 48 Leslie A. Riley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1948 at 2 - A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Coronary artery disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Mount Deputy Medical Examiner

M. D. or other

Address Westminster Md Date signed Apr 26/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

03739

Reg. Diat. No. 72

1. PLACE OF DEATH:
County: Carroll
City or town: Silver Run, Westminster R.D.1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Silver Run, Westminster R.D.1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emma Catherine Myers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Franklin H. Myers
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): April- 11- 1872

8. AGE: Years	Months	Days	If less than one day
75	11	26	hrs. min.

9. Birthplace: Adams County, Pa. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: In own home.

FATHER
12. Name: Aaron Myers
13. Birthplace: Adams County, Pa.

MOTHER
14. Maiden name: Lydia Arter
15. Birthplace: Adams County, Pa.

16. Informant: George L. Myers
Address: Silver Run, Westminster, Md. R.D.1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/10/48 (month) (day) (year)
Cemetery or crematory: St. Marys Union Cemetery.
Location: Silver Run, Md.

18. Funeral director: J. M. Little & Son
Address: Littlestown, Pa. Per R. S. Little

19 April 9th 1948 (Date rec'd by registrar) Calvin Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to April 7 1948 and that I last saw h alive on April 7 1948

Immediate cause of death	DURATION
Acute pulmonary edema	5h
Due to: Chronic cardio-vascular disease	10 yr
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Donald B. Carver M. D. or other
Address: Littlestown Pa. Date signed 4-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03740

Reg. Dist. No. 76

M

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME J. Irvin Myers

3.(b) Social Security Number 216-22-7932

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Lilah Hellentridle Myers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 5, 1894

8. AGE: Years: 63 Months: 9 Days: 14 If less than one day ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER 12. Name: Lewis Myers

13. Birthplace: Md

MOTHER 14. Maiden name: Missouri Nusbaum

15. Birthplace: Md

16. Informant: Mrs J. Irvin Myers

Address: Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 22, 1948 (month) (day) (year)

Cemetery or crematory: Lutheran

Location: Uniontown Md

18. Funeral director: C O Dutrow Sons

Address: Taneytown Md

19. 4/21 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1948, at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 1947 to Apl 19 1948 and that I last saw him alive on April 19 1948

Immediate cause of death	DURATION
Carcenoma Prostate	
Due to Operation 1943	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Md Date signed: 4-20-48

DATE: letter from Dr. Saffell filmed G120 6-8-49 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03741

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Lawsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Carroll
City or town Lawsville (If outside city or town limits, write RURAL and give nearest town)
Streal No. Finksburg P. O. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Stanley G. Parks, Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Lillian Nicholes
6.(c) If alive, give age yaars

7. Birth data of deceased (mo., day, yr.) May 2, 1919

8. AGE: Years 28 Months 11 Days 17 If less than one day hrs. min.

9. Birthplace Lydesville, Md. (Town, county, and state)
10. Usual occupation Operator
11. Industry or business Bendix Corp.
FATHER 12. Name Stanley G. Parks
13. Birthplace Md.
MOTHER 14. Maiden name Catherine Kraft
15. Birthplace Md.
16. Informant Mrs. Lillian Parks
Address Finksburg, Md.
17. Burial (Burial, cremation, or removal Which?) Date thereof Apr. 22, 1948 (month) (day) (year)
Cemetery or crematory Lisbon Hill Cemetery
Location Lydesville, Md.
18. Funeral director C. Harry Weer
Address Lydesville, Md.
19. Apr. 21 1948 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19-48 1948 at 12 Mid-night

21. I CERTIFY that daath occurred on tha date abova statad; that I attended decaased from August 1947, to 4-16-48 1948
and that I last saw him alive on 4-17-48 1948

	DURATION
Immediate cause of death	
Pulmonary Tuberculosis	
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE James G. Saffell M.D. M. D. or other
Address Reisterstown Date signed 4/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03742

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: CARROLL
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Woodbine, rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM WASHINGTON PICKETT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWED

6.(b) Name of husband or wife: Annie Catherine Hargett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 6, 1870

8. AGE: Years	Months	Days	If less than one day
77	4	21	hrs. min.

9. Birthplace: Howard County (Town, county, and state)
10. Usual occupation: Hospital Attendant
11. Industry or business:

FATHER
12. Name: William David Pickett
13. Birthplace: Howard County, Maryland

MOTHER
14. Maiden name: Mandy Bowman
15. Birthplace: Howard County, Maryland

16. Informant: John E. Pickett
Address: Winfield, Maryland

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 5-1-48 (month) (day) (year)
Cemetery: Poplar Springs
Location: Poplar Springs, Howard Co. Md.

18. Funeral director: C.M. Waltz
Address: Winfield & Woodbine, Maryland

19. Apr. 30 1948 (Date rec'd by registrar) C. Henry Wells Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1948 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 1948 to April 28 1948 and that I last saw h. alive on April 28 1948.

	DURATION
Immediate cause of death: Carcinoma of Stomach	4 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Sykesville, Maryland Date signed 4/28/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

County ....

City or town ....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ....

Hospital, institution, or street address where death occurred:
....

How long in hospital or institution? ....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State .... County ....

City or town ....
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war ....

3. (a) FULL NAME | **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife ....

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) ....

8. AGE: Years	Months	Days	If less than one day
			.... hrs. .... min.

9. Birthplace ....
(Town, county, and state)

10. Usual occupation ....

11. Industry or business ....

FATHER
12. Name ....
13. Birthplace ....

MOTHER
14. Maiden name ....
15. Birthplace ....

16. Informant ....
Address ....

17. (Burial, cremation, or removal. Which?) .... Date thereof .... (month) (day) (year)

Cemetery or crematory ....

Location ....

18. Funeral director ....
Address ....

19. .... 19...... Registrar ....
(Date rec'd by registrar)

RECEIVED
MAY 3 1948
BUREAU V. S.

MEDICAL CERTIFICATION

20. DATE OF DEATH .... 19...... at .... M

21. I CERTIFY that death occurred on the date stated above; that I attended deceased from .... 19...... to .... 19......
and that I last saw h...... alive on .... 19......

	DURATION
Immediate cause of death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....

Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work? ....

23. SIGNATURE .... M. D. or other

Address .... Date signed ....

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information asked for. Physicians: Please state the causes of death clearly and legibly. A correct age is especially important.

MARGIN RESERVED FOR BINDING

VS AIP 5-42-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03743

97

CERTIFICATE OF DEATH

Reg. Dist. No. 80

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred: Jacontown

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Rural - Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Jacontown

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Temma Ann Wilkinson Potter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widowed

6.(b) Name of husband or wife: Clifford I. Potter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 30, ~~1867~~ 1866

8. AGE:

Years	Months	Days	If less than one day
82	2	21	..... hrs. ..... min.

9. Birthplace: Wells Vt. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Robert Wilkinson

FATHER 13. Birthplace: —

MOTHER 14. Maiden name: Roxanna Beebe

MOTHER 15. Birthplace: Vermont

16. Informant: Mrs. Myra Thacker

Address: Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/24/48 (month) (day) (year)

Cemetery or crematory: Granvelle Cemetery

Location: Granvelle New York

18. Funeral director: W. H. Hartley & Sons

Address: Union Bridge & Westminster Md

19. April 21 1948 Ernest D. Bucher

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 47 to Apr 20 19 48 and that I last saw her alive on Apr 6 19 48

Immediate cause of death	DURATION
Generalized Arteriosclerosis	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James V. Monroe M. D. or other

Address: Westminster Md Date signed 4/20/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03744

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CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs 6 mos 23 da
Hospital, Institution, or street address (if not in hospital): Springfield State Hospital
How long in hospital or institution? 2 yrs 6 mos 23 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Rose Emma Repp.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
F	W	Widowed.

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 17th 1885

8. AGE: Years 62 | Months 11 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business at home

MOTHER FATHER
12. Name Isaac Stambaugh
13. Birthplace Md
MOTHER
14. Maiden name Joanna Gelk
15. Birthplace Md

16. Informant Jesse Phoebe May Gaia
Address 1706 W Baltimore St Balto

17. Removal Date thereof 4-6-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Frederick, Md.

18. Funeral director M. R. Eichelman & Son
Address Frederick, Md.

19. April 6 1948 C. Henry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1948, at 6-47 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 14th 1945, to Apr 6 1948
and that I last saw h— alive on April 6th 1948

Immediate cause of death	DURATION
Terminal Bronchopneumonia	24 hrs
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. J. Gaston M.D.
M. D. or other
Address Sykesville Md. Date signed 4/6/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03745

136

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore [illegible]

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1132 E. Lombard St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HELEN ROBERTS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 28, 1895

8. AGE: Years	Months	Days	If less than one day
52	11	29	hrs. min.

9. Birthplace: Southerland, Va. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Charles Dadman

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Henrietta Walker

15. Birthplace: Southerland, Va.

16. Informant: Daughter-Mrs. Doris Franklin

Address: 1132 E. Lombard St. Balto. Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 4/20/1948 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: A.A. County, Md.

18. Funeral director: Robert E. Williams

Address: 1515 McElderry St.

19. 4/16 19 48 (Date rec'd by registrar) Albert R. Jonathan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 19 48 at 4.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12, 19 48 to April 16, 19 48 and that I last saw her alive on April 16, 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dalas W. Fuqua, M. D. M. D. or other

Address: Henryton, Md Date signed: 4/16/48

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

03746

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 111a

CERTIFICATE OF DEATH

Reg. Diat. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? - 19 yrs
Hospital, institution, or street address where death occurred: Hampstead
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hampstead
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME Clayton Eugene Rupp

3.(b) Social Security Number 212-26-6838

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1928

8. AGE:

Years	Months	Days	If less than one day
19	7	5	____ hrs. ____ min.

9. Birthplace Hampstead, Carroll Co. Maryland (Town, county, and state)

10. Usual occupation - Laborer

11. Industry or business

FATHER
12. Name Richard Russell Rupp
13. Birthplace Hampstead, Md

MOTHER
14. Maiden name Carrie Irene Spencer
15. Birthplace Lawndale Maryland

16. Informant Mrs Richard Russell Rupp
Address Hampstead, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 29/48 (month) (day) (year)
Cemetery or crematory Hampstead
Location Carroll Co Md

18. Funeral director Edw C Fraton
Address Hampstead Md

19. April 29 1948 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1948 at 2:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1948 to April 27 1948 and that I last saw h.im alive on April 27 1948

Immediate cause of death	DURATION
Pulmonary Embolus	
Due to Malignant Hypertension	6 Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE W. H. Howard M D
M. D. or other
Address Manchester, Md Date signed April 27 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03747

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years, 1 month, 25 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 18 years, 1 month, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3506 Plateau Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Florence Shepherd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Clarence M. Shepherd

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1888 (months and day unknown)

8. AGE: Years	Months	Days	If less than one day
60	unknown		hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Davis E. Laudis

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Sarah Backtel

15. Birthplace: Pennsylvania

16. Informant: Hpspital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal? Which?) Date thereof Apr 13 1948 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Woodlawn Md.

18. Funeral director: Wm. J. Tuckner & Sons

Address: North & Penna. Ave. Baltimore

19. Apr. 11 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1948 at 4.30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 2, 1942 to April 10, 1948

and that I last saw her alive on April 9, 1948

Immediate cause of death	DURATION
Cancer of the stomach	10 months
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type	23 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Irene H Holmes M.D. (M. D. or other)

Address: Springfield State Hospital Date signed: 4-10-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03748

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 mos.

Hospital, Institution, or street address where death occurred:

Winnie Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Louise Shriver

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 19 – 1871

8. AGE: Years 76 | Months 6 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER — 12. Name David Kuener Shriver

13. Birthplace Carroll Co. Md.

MOTHER — 14. Maiden name Clementine Snader

15. Birthplace Carroll Co. Md.

16. Informant Margaret Shriver (mrs)

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2-1948 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 5/1 (Date rec'd by registrar) 1948 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1948 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940 to April 30 1948

and that I last saw h[illegible] alive on April 30 1948

	DURATION
Immediate cause of death: Coronary Occlusion	3½ hrs
Due to: arteriosclerosis	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E Reese Wilkens M. D. or other

Address Westminster Date signed 5/30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

03749

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month, 26 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give neareat town)

Street No. 1127 W. Franklin St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: CHARLES DANIEL SPENCER

3.(b) Social Security Number: 218-01-6755

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Delores Spencer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 18, 1917

8. AGE: Years	Months	Days	If less than one day
30	8	28	hrs. min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER
12. Name: Daniel Spencer
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Georgiana Dugan
15. Birthplace: Annapolsi, Md.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/21/1948 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: Baltimore Md

18. Funeral director: Robert E Williams

Address: 1515 McElderry St

19. 4/16 19 48 (Date rec'd by registrar) Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: April 16, 19 48 at 10.25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19, 19 48 to April 16 19 48 and that I last saw him alive on April 16 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Md Date signed 4/16/48

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03750

123

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Albert Henry Stine III

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 26-1948

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Albert Stine
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Wilbert
15. Birthplace: Maryland

16. Informant: Albert Stine
Address: Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/29/48 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Middletown, Md.

18. Funeral director: H. H. Hartsler & Sons
Address: Union Bridge Route Hundson, Md.

19. April 29 1948 P. Eichelberger
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1948 at 11:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1948 to April 28 1948 and that I last saw him alive on April 27 1948

Immediate cause of death	DURATION
Convulsions	
Due to constipation	
Due to no further inf. - child not healthy at birth	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. W. Leppo M. D. or other
Address: Union Bridge Date signed 4-28-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03751

97

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie M. Townsend

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife William S. Townsend
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 19 1857

8. AGE: Years 90 | Months 5 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER
12. Name Frederick Stonesifer
13. Birthplace Maryland

MOTHER
14. Maiden name Elmyra Shipley
15. Birthplace Maryland

16. Informant Mrs. Beulah Townsend
Address Bangor, Pennsa.

17. Burial (Burial, cremation, or removal? Which?) Date thereof April 20-48 (month) (day) (year)
Cemetery or crematory Pipe Creek Cemetery
Location Uniontown Road
18. Funeral director W. H. Hartsburg & Son
Address Union Bridge & New Windsor, Md.

19. April 19, 1948 (Date rec'd by registrar) Richman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 1948 to April 17 1948 and that I last saw h.. alive on April 17 1948

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. H. Legg M. D. or other
Address Union Bridge Date signed 4-19-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

CERTIFICATE OF DEATH

03752

Reg. Dist. No. 74

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs 3 mos 27 da

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 10 yrs 3 mos 27 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: P. George

City or town: Mitchellville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Ethel May Walker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: V

6.(c) If wife, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 20th - 1917

8. AGE: Years 30 | Months 8 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace: md.
(Town, county, and state)

10. Usual occupation: not any

11. Industry or business:

FATHER
12. Name: Shipley B Walker
13. Birthplace: Washington D C

MOTHER
14. Maiden name: Mary E Carhart
15. Birthplace: Md

16. Informant: Shipley B Walker
Address: Mitchellville Md

17. (Burial, cremation, or removal. Which?) Date thereof April 15th 1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Prince George Co

18. Funeral director: J Wm Lee Sons Co

Address: 300 4th St NE Washington D C.

19. Apr 13 1948 (Date rec'd by registrar) A Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12th 1948 at 2-55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16th 1937, to April 12 1948 and that I last saw h[illegible] alive on April 12 1948

Immediate cause of death	DURATION
Status Epilepticus	3 da
Due to	
Due to Epilepsy	27 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: J J Gaston M D
M. D. or other

Address: Sykesville Md Date signed 4/12/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03753

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 month 15 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or Institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1224 Pennsylvania Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William Henry Scott Wallington

3.(b) Social Security Number: 215-16-0022

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 24, 1924

8. AGE: Years	Months	Days	If less than one day
23	9	8	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business:

FATHER
12. Name: William Wallington
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Hattie Scott
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-4-48 (month) (day) (year)

Cemetery or crematory: Arbutus Mem. Pk.

Location: Arbutus Md.

18. Funeral director: Joseph M. Locke

Address: 1604 N. Central ave.

19. April 1 1948 (Date rec'd by registrar) Albert R. Swandham Registrar
Local Deputy

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: April 1 1948 at 7:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17 1947, to April 1 1948 and that I last saw h... im alive on April 1 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	October 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Palmer Wyman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 4/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03754

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Linebora

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Linebora

(If outside city or town limits, write RURAL and give nesrest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MARGARET A. TRACY WERTZ

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William H. Wertz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 9, 1875

8. AGE:

Years	Months	Days	If less than one day
73	0	0	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Home keeper

11. Industry or business

FATHER

12. Name: John W. Tracy

13. Birthplace: Md

MOTHER

14. Maiden name: Margaret Wentz

15. Birthplace: Pa.

16. Informant: Mrs. Samuel W. Warner

Address: Linebro, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 13, 1948 (month) (day) (year)

Cemetery or crematory: Lazarus Reformed

Location: Linebora Md.

18. Funeral director: H. C. Gepfe & Son

Address: Glen Rock, Pa. Per H.C. Gepfe

19. Apr. 10 (Date rec'd by registrar) 1948 Mrs. W. F. J. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1948 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 1947 to April 9 1948 and that I last saw h[illegible] alive on April 8 1948

Immediate cause of death	DURATION
Generalized Carcinomatosis	
Due to: Primary Carcinoma Ovary	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Ovary - acute appendicitis Date of op. Oct 15-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Bush M.D. M. D. or other

Address: Hampstead Md. Date signed 4-10-48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03755

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs 9 mos 6 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 15 yrs 9 mos 6 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore Co.

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Paul Whitcomb.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 1st. 1918

8. AGE: Years 30 | Months — | Days 2 | If less than one day: hrs. min.

9. Birthplace: Baltic Co. (Town, county, and state)

10. Usual occupation: not any

11. Industry or business:

FATHER 12. Name: John Whitcomb.

13. Birthplace: Baltic Co.

MOTHER 14. Maiden name: Annie K Diehl.

15. Birthplace: Pennsylvania

16. Informant: John Whitcomb

Address: Sykesville Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) April (day) 6 (year) 48

Cemetery or crematory: Ristertown Methodist

Location: Ristertown Balto Co.

18. Funeral director: J. F. Elms. Sons

Address: Ristertown Md.

19. (Date rec'd by registrar) April 6 1948 C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3d 1948 at 6.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1932 to Apr 3d. 1948 and that I last saw him alive on April 3d 1948

Immediate cause of death	DURATION
Bronchio Pneumonia	3 da
Due to	
Epilepsy	28 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Martin M.D. M. D. or other

Address: Sykesville Md. Date signed: 4/3/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03756

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years, 11 months 3 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 7 years, 11 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 750 Maryland Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war V

3.(a) FULL NAME

Walter Wolverton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Bertie Wolverton

6.(c) If alive, give age unkn. years

7. Birth date of deceased (mo., day, yr.) June 3, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	16	..... hrs. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation carpenter

11. Industry or business

FATHER 12. Name Charles Wolverton

13. Birthplace Virginia

MOTHER 14. Maiden name Caroline Day

15. Birthplace Virginia

16. Informant Records of Springfield Hospital

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 23 1948 (month) (day) (year)

Cemetery or crematory Cumberland

Location Cumberland, Md.

18. Funeral director C. L. George

Address Cumberland, Md.

19. Apr. 19 19 48 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 48 at 12:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 19 47, to April 19 19 48 and that I last saw him alive on April 19 19 48

Immediate cause of death	DURATION
Arteriosclerosis	More than 8 yrs.
Due to	
Due to	
Other conditions Arteriosclerotic gangrena, myocardial changes & hypertension	9 weeks Many yrs.
(Include pregnancy within 3 months of death) Chronic alcoholism	Many yrs.

Major findings of operations Amputation of left gangrenous leg Date of op. 3/23/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin Gross, M.D.
Martin Gross, M.D., D.O. or other

Address Sykesville, Maryland Date signed 4/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03757

Reg. Dist. No. 71

M

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Lancaster

City or town: Rural - Lancastertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred: Route 71 -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: York Co.

City or town: Route #1 York

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION) ✓

2.(a) If veteran, name war

3.(a) FULL NAME John H. Waylie

3.(b) Social Security Number

4. Sex: M

5. Color or race: W.

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife: Clara E. Waylie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 26 - 1885

8. AGE: Years: 63 | Months: 1 | Days: 21 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Zanesville, Ohio (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Feed Business

FATHER 12. Name: William A. Waylie

FATHER 13. Birthplace: Vermont

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace:

16. Informant: Mrs Alden W. Waylie

Address: Lancaster, Pa.

17. Is burial (Burial, cremation, or removal. Which?) Date thereof April 22 - 1948 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: York Co. York Pa.

18. Funeral director: Edw A. Baermeste

Address: York, Pa.

19. April 19 1948 (Date rec'd by registrar) Mary B. Witt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19.... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Wood Deputy Medical Examiner M. D. or other

Address: Witmanstown Pa. Date signed 4/19/48